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A Comprehensive Review of Haemorrhoids with Unani (Greco-Arabic) and Modern Description

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Abstract

Bawaseer (Haemorrhoid) is one of the most common and nagging anorectal disorder of mankind. They are specialized highly vascular cushions of discrete masses of thick sub mucosa, containing blood vessels, smooth muscles, elastic and connective tissue which may slide down due to breakage of collagen and anchoring supporting connective tissue causing symptoms like prolapse, pain, bleeding etc. They do not constitute a disease, unless they become symptomatic. Symptomatic haemorrhoids affect at least 50% population at some time during their lives, with around 5% of the population suffering at any given time, and both sexes experiencing the same incidence of the condition. Exact cause of haemorrhoids is still unknown and there exist many myths regarding the aetiology and pathophysiology of haemorrhoids. Haemorrhoids have several treatments but the best treatment is always prevention. They can be prevented by some life style modification. In initial stages conservative treatments can be applied, but over a period when the haemorrhoids get worst, the disease should be treated by several non-operative and surgical treatments like, Sclerotherapy, rubber band ligation, infrared photocoagulation, cryotherapy, bipolar diathermy, direct-current electrotherapy and haemorrhoidectomy. Unani System of Medicine (USM) has also a comprehensive description of the management for haemorrhoids and Unani therapy and formulations are also found to be effective in the management and prevention of haemorrhoids.

Keywords: Bawaseer, Haemorrhoids, Anorectal disorder, Life style, Unani, Greco-Arabic

Introduction

The word “haemorrhoid” is derived from the Greek word ‘haema’ (blood) and ‘rhoos’ (flowing), and it was probably Buqrat (Hippocrates) (460 BC) who was the first to apply the name to the flow of blood from the veins of the anus. The term “piles” is derived from the Latin “pila” (a ball) and was widely used by the public at the time of John of Arderne (born: 1307 AD), and in his treatise of 1370 he remarks that the ‘common people call them piles, the Aristocracy call them haemorrhoids and the French call them figs (figer, to clot)^{1,2,3}.

As per Unani (Greeco-Arabic) literature, haemorrhoids are known as “*Bawaseer*”. *Bawaseer* is the plural of baasoor, which means wart or polyp like swelling⁴.

Definition:

Haemorrhoids have been defined differently over the years from oversimplified definition of haemorrhoidal plexus to the more recent study describing

them as specialized highly vascular cushions of discrete masses of thick sub mucosa, containing blood vessels, smooth muscles, elastic and connective tissue which may slide down due to breakage of collagen and anchoring supporting connective tissue causing symptoms like prolapse, pain, bleeding etc^{5,6}.

As per Unani literature, most of the physicians described *Bawaseer* in detail according to their observation. According to Buqrat, *Bawaseer* is the varicosities of the internal mucous membrane of rectum in which the veins get swollen similar to the veins of lower limb.⁷

According to Samarqandi (died 1222 AD), *Bawaseer* is the warty swelling at the end of rectal veins due to viscid saudawi blood⁷.

According to Ali Ibne Abbas Majoosi and Abu Marwan Ibne Zuhar, *Bawaseer* is the growth or swelling at the end of the vessels of the rectum^{8,9}.

According to Hakim Azam Khan, *Bawaseer* is the swelling at the end of the rectal vessels due to accumulation of saudawi blood⁴.

Similarly all eminent Unani physicians described *Bawaseer* in detail but the concept is more or less same as mentioned above^{10,11,12,13}.

This condition mainly develops in rectum because in this region number of veins are numerous than other part of intestines and also at this site faeces become more solid and dry and exerts pressure on this region⁷. Although most people think haemorrhoids are abnormal, they are present in everyone. It is only when the haemorrhoidal cushions enlarge to the extent that cause problems and be considered as abnormal or a disease.

Anatomy and Physiology

Haemorrhoids are vascular cushions within the anal canal, usually found in three main locations: left lateral, right anterior, and right posterior portions. They lie beneath the epithelial lining of the anal canal and they receive their blood supply primarily from the superior and middle haemorrhoidal arteries; the superior, middle and inferior haemorrhoidal veins provide venous drainage. A sinusoidal pattern of arteriovenous communication is formed within the cushions, which explains why the haemorrhoidal bleeding is arterial, rather than venous in nature. In addition, the haemorrhoidal cushions are also rich in muscular fibres, arising from the internal sphincter and the conjoined longitudinal muscle. These fibres help to anchor the cushions to the underlying muscular layer of the anorectum, and it is the breakdown of these supporting fibres that eventually leads to the changes that can cause the haemorrhoidal symptoms. The cushions play an important role in the maintenance of rectal continence, as they contribute approximately 15- 20% of the resting anal pressure, so they intensify the action of the anal sphincter mechanism and shield the anal canal and the anal sphincter during the act of evacuation by filling with blood and providing extra padding. The epithelial layer of anorectum is characterised by the relatively insensitive columnar epithelium that covers the internal haemorrhoidal cushions (mucosa) and the extremely sensitive squamous epithelium, which extends up into the anus (anoderm). The junction of these two epithelial layers is known as the

dentate line (pectinate line) and is typically located approximately 3 cm inside the anal verge. This line marks the transition between columnar epithelial-covered internal haemorrhoids and the squamous epithelial-covered external haemorrhoidal vessels^{14,15}.

Epidemiology

Many individuals experience this condition without seeking medical consultation; patients are often reluctant to seek medical help because of embarrassment or the fear, discomfort, and pain associated with the treatment, so the exact incidence of this disease cannot be estimated.

Age incidence

The age distribution of haemorrhoids demonstrated a hyperbolic pattern with a peak between age of 45-65 years and a subsequent decline after the age of 65 years. In the age group of 45-65 years, it has estimated that 50-85% of people around the world have haemorrhoids. The presence of haemorrhoids in patients less than 20 years is unusual¹⁶.

Sex incidence

Both sexes experience approximately the same incidence of haemorrhoids, but if both symptomatic and asymptomatic haemorrhoids are taken into consideration the presence of haemorrhoids are marginally more in males.^[17,18]

Socioeconomic and diet status

Haemorrhoids are particularly rare in communities, which have departed least from their traditional manner of life, but more in economically developed communities. They are more common in Caucasians and those of higher socioeconomic status. There is a close relationship with western type of diet, which is more refined and low in fibre increasing bowel transit time and forming hard stools. There is considerable evidence that haemorrhoids become commoner with progressive adoption of a more western way of life^{15,17}.

Occupation

People whose occupation require prolong sitting (e.g. drivers, clerks etc.), standing (e.g. security guards etc.) or heavy weight lifting (e.g. weight lifters, coolies, etc.) are at higher risk for developing haemorrhoids. Washaw LJ and Turell noted a number of patients in whom occupation stress or strain played an important role in precipitating prolapse of existing internal haemorrhoids.^{5,19}

General incidence and prevalence of haemorrhoids

According to NIH data, nearly 1 million cases are reported annually in US at the prevalence rate of 4.4%. It is estimated that 58% of people aged over 40 years have the disease in the US. Some researchers suggest that about 75% of people will have symptomatic haemorrhoids at some point of time in their lives^{16,20}.

In India approximately 40,723,288 people are reported to have haemorrhoids. One million new cases are reported annually, at the rate of 47 per 1000 and this rate increases with age. Current statistics suggest nearly half of the world's population will experience some form of haemorrhoids especially when they reach the golden age of fifty²¹.

According to several studies carried out in high-risk groups, the prevalence rate of haemorrhoids is very high. A study carried out in four hospitals in Austria, for the screening of the colorectal cancer in which 38.93% individuals were diagnosed as having haemorrhoids²².

A study conducted in United States, regarding the incidence and prevalence of haemorrhoids, it is found that approx 1 in 26 or 3.82 % or 10.4 million people have haemorrhoids in United States of America. In the US, about 4.4% of the general population has haemorrhoids which occur more often in Caucasians from rural areas and in those with higher socio-economic status. According to the same statistics, Deaths: 17, Hospitalizations: 3,16,000, Physician office visits: 3.5 million, Prescriptions: 1.5 million, Disability: 52,000 people have been reported due to haemorrhoids²¹. A study was conducted regarding the prevalence of haemorrhoids, in which the clinical records of 835 patients (at the Colon and Rectal Surgical Clinic of Henry Ford Hospital, Detroit) were reviewed. Among them 594 had symptoms of haemorrhoids and 241

had no symptoms (asymptomatic group). Among the symptomatic group 88% and among the asymptomatic group 82% had haemorrhoids. It was felt that if the prevalence rate of haemorrhoids in the symptomatic and asymptomatic groups is similar or close to similar in every age, it is likely that a certain number of people will have haemorrhoids in every age group irrespective of the presence or absence of symptoms¹⁸.

Classification and grading of haemorrhoids

Haemorrhoids are classified according to their origin; the dentate line (pectinate line) serves as an anatomic-histologic border. External haemorrhoids originate distal to the dentate line and internal haemorrhoids originate proximal to the dentate line. In some patients the two types coexist.

External haemorrhoids:

External haemorrhoids originate distal to the dentate line, arising from the inferior hemorrhoidal plexus. They are sometimes painful as they are lined with modified squamous epithelium, which is richly innervated with somatic pain fibres (delta type, unmyelinated), and often accompanied by swelling and irritation. External haemorrhoids are prone to thrombosis, they become thrombosed when the vein ruptures and/or a blood clot develop^{5,6,17}.

Internal haemorrhoids:

Internal haemorrhoids are symptomatic, originate proximal to the dentate line, arising from the superior hemorrhoidal plexus, and are covered with mucosa. According to Goligher's classification, internal haemorrhoids are subdivided into 4 grades according to the extent of prolapse²³.

1. First-degree haemorrhoids:

The hemorrhoidal tissue bulges into the lumen of the anal canal, (can be inspected only, not felt) and may or may not produce painless bleeding.

2. Second-degree haemorrhoids:

They protrude at the time of bowel movement and reduce spontaneously.

3. Third-degree haemorrhoids:

They are those that protrude spontaneously or at the time of bowel movement and require manual reduction.

4. Fourth-degree haemorrhoids:

They are those that are permanently prolapsed and irreducible despite attempts at manual reduction.

On basis of lithotomy position, there are usually three major haemorrhoidal cushions originated to the right posterior, right anterior and left lateral position known as 3, 7 and 11 O'clock position of the anal canal^{2,5}.

Interno-externo (mixed) haemorrhoids:

Are those with elements of internal and external haemorrhoids i.e. arising from the inferior and superior hemorrhoidal plexi and their anastomotic connections and are covered by mucosa in the superior part and skin in the inferior part^{2,3,5,6,14,17}.

Unani physicians classified *Bawaseer* on the following basis:

1. According to the site of appearance/location
2. According to the shape of masses
3. According to the bleeding/haemorrhage

1. According to the site of appearance/location

According to the site of appearance *Bawaseer* are of two types:

- i) **Nabita** – protrudes out from the rectum during defecation and can be called as external piles.

- ii) **Ghaira** – it is deep seated and not protrudes from the rectum and can be called as internal piles.

2. According to the shape of masses

According to the shape, *Bawaseer* are of seven types:

- i) **Sololi** – it is similar to small warts (that are present all over the body), and it is worst among all types.
- ii) **Inabi** – it is round and slight broad in size similar to grapes and *arghwani* (purple) in colour.
- iii) **Tooti** – it is loose and soft, and red in colour similar to mulberry.
- iv) **Nafakhi** – it is white in colour, and painless and similar to *ulse naffakha*, which is obtained from fish's stomach.
- v) **Nakhali** – similar to the branches and roots of the date tree, which spreads in all direction.
- vi) **Tabni** – it is flat similar to fig.
- vii) **Tamari** – it is slight hard similar to date.

Out of 07 types that are discussed above, first 3 are more common and because of this most of the unani physicians mainly describe these 3 types.

3. According to bleeding/haemorrhage, *Bawaseer* classified as:

- i) **Munfatiha** – in which there is bleeding and also known as *Bawaseere Khooni*.
- ii) **Umiya** – in which there is no bleeding and also known as *Bawaseere Reehi*^{4,7,8,13,24,25,26}.

Aetiology and Pathophysiology

The cause of haemorrhoids is still hypothesized and there exist many myths regarding the aetiology and pathophysiology of haemorrhoids.

Some of the earliest proposed aetiologies included temperament, body habits, customs, passions, sedentary lifestyle, tight-laced clothes, climate and seasons.

According to recent studies, several theories have been postulated regarding the cause, including prolonged periods of driving, erect posture, chronic constipation and diarrhoea, straining during defecation, low fibrous diet, heredity, eating spicy foods, sitting on cold seats and benches, doing manual labour, lifting heavy weights, being overweight, pregnancy, weakening of the connective tissue in the rectum and anus that occurs with age.^[3,5,6,27,28] None of these theories has strong experimental support.

Alcoholic cirrhosis or other causes of portal obstruction can cause severe haemorrhoids. More rarely but much more importantly, haemorrhoids may reflect collateral anastomotic channels that develop as a result of portal hypertension¹³.

Tumours in the pelvis also cause enlargement of haemorrhoids by pressing on veins draining upwards from the anal canal²⁹.

One theory proposes that it is the shearing (pulling) force of stool, particularly hard stool, passing through the anal canal that drags the haemorrhoidal cushions downward^{2,30}.

Another theory suggests that with age or an aggravating condition, the supporting tissue that is responsible for anchoring the haemorrhoids to the underlying muscle of the anal canal deteriorates. With time, the haemorrhoidal tissue loses its mooring and slides down into the anal canal^{2,30}.

One physiological fact that is known about enlarged haemorrhoids that may be relevant to understanding why they form is that the pressure is elevated in the anal sphincter (the muscle that surrounds the anal canal and the haemorrhoids). The anal sphincter is the muscle that allows us to control our bowel movements. It is not known, however, if this elevated pressure precedes the development of enlarged haemorrhoids or is the result of the haemorrhoids. Perhaps during bowel movements, increased force is required to force stool through the tighter

sphincter. The increased shearing force applied to the haemorrhoids by the passing stool may drag the haemorrhoids downward and enlarge them^{2,30}.

In an interesting study conducted by Ahmed and Thomson (1997) it was found that there is a correlation between failure to eat breakfast and the development of haemorrhoids³¹.

According to Balch & Balch (2000), haemorrhoids are unique to human beings, indicating that our dietary and nutritional habits play an important role in this disorder³¹.

As per Unani literature, following are the main causes of haemorrhoids:

1. Most of the times haemorrhoids are due to *saudawi madda* (matter) and rarely it is due to *balghami madda*, and when it is due to *balghami madda* it looks like *nuffakhat*. *Sololi* type of haemorrhoids is due to *saudawi madda* and *tooti* is due to *damawi maada* and *inabi* is due to the *madda* which is in between *sauda* and *dam* (blood) or which is the mixture of *sauda* and *dam*.

Saudawi blood is the main cause of haemorrhoids. This saudawi blood develops mainly due to 02 reasons:

- i) Due to consumption of drugs (hot in temperament) and hot, spicy substances and due to *saфра* (when it mixes with the blood), blood becomes *sokhta* (burnt) and *ghaleez* (viscous).
 - ii) Due to *ghaleez dam* (viscous blood), that develops due to excessive consumption of saudawi substances^{4,7,8,24,25}.
2. According to *Mohammad Bin Zakariya Razi*, haemorrhoids may also develop due to excessive consumption of *saudawi* and sweet substances²⁴.
 3. According to some physicians, haemorrhoids may also develop in those persons who used to sit more in latrine, especially those latrines that are utilized by haemorrhoids' patients.^[4,7,25]
 4. According to *Ibne Looqa*:
 - i) Haemorrhoids are very common in those persons who consume more *Roghane Baid Injeer*.
 - ii) Haemorrhoids are also very common in those persons who are the natives of the places where the air is *ratab* (moist) and *mutaaffin* (putrefied) and in those persons who consume more dates, milk, fish and other dry fruits.
 - iii) Persons of *saudawi* temperament are more prone to develop haemorrhoids^{4,25}.
 5. According to *Ibne Sina*, haemorrhoids are also very common in southern areas, and commonly develop due to the continuous blowing of southern winds²⁶

Clinical Manifestations:

Principal complaints of haemorrhoids include bleeding on defecation and prolapse of tissue. Secondary symptoms may be associated with haemorrhoids but often arise from other causes that are unrelated. Contrary to popular belief, pain is not a primary symptom and usually occurs as a result of complications of haemorrhoids^{1,2,3}.

Principal Symptoms

Bleeding on Defecation:

Rectal bleeding is the most common symptom of haemorrhoids. Hemorrhoidal bleeding is bright red and painless. If there is pain, another diagnosis such as a fissure should be entertained. It usually occurs at or immediately after defecation. Blood is not mixed with stools. It is usually small in amount but occasionally patients may experience heavy bleeding. Blood dripping or squirting into the bowl at the end of defecation is highly suggestive of haemorrhoids^{1,2,3}.

According to *Jalinoos*, it is impossible that a patient has haemorrhoids and there is no bleeding. In *Bawaseer* liver sends viscous, foul and *saudawi* blood towards rectum which leads to the hypermia of the rectal vessels and this leads to the perforation of the vessels and ultimately bleeding. Sometimes bleeding is cyclical and sometimes it is acyclical. Some patients of haemorrhoids also complain about the epistaxis and this is beneficial for them^{24,26}.

Prolapse:

Prolapse is another common symptom of haemorrhoids. It occurs in larger haemorrhoids. Hemorrhoidal prolapse usually occurs at the time of defecation. It is usually painless and reduces spontaneously after defecation in 2nd grade of haemorrhoids, in 3rd grade it requires manual reduction and 4th grade haemorrhoids are trapped outside the anal canal and cannot be reduced by manual pressure.

According to *Mohammad Bin Zakariya Razi*, in this disease (haemorrhoids), sometimes rectum prolapses externally and then remains in that condition. In the same context, he also states that, sometimes due to *warama haar* (inflammation) spasmodic condition develops in the rectum which results in the prolapse and swelling of the rectum²⁴.

Secondary Symptoms**Mucus Discharge:**

Mucus is produced by the secretory columnar epithelium above the dentate line. When the prolapse is significant enough to protrude through the anal canal, the columnar mucosa is exposed to the outside environment and becomes irritated, thus secretes mucus^{1,2}.

Pain:

Pain is usually not a feature of haemorrhoids and should raise the possibility of another disease such as a fissure or abscess. Prolapsed haemorrhoids can cause a dragging sensation until they are reduced. Once the prolapse is reduced, the discomfort quickly resolves^{1,2,3,5}.

According to *Ismail Jurjani*, if there is burning and throbbing pain then it is due to *safravi* matter and along with pain if patient feels fatigue and restlessness then it is due to *ghaliz dam* (viscid blood). In bleeding piles, if, due to any reason, bleeding stops it causes severe pain and itching in the rectum²⁵.

Pruritis:

Mucus discharge can cause maceration and irritation of skin leading to pruritis. Most often, however pruritis is secondary to other causes such as infections or dermatological conditions^{1,2,3,5}.

Anaemia:

Anaemia can be caused by bleeding haemorrhoids very rarely so this can be called as complication rather than a symptom^{1,2,3,5,6}.

According to *Mohammad Bin Zakariya Razi*, when there is excessive bleeding, the patient appears pale and whitish due to the dominance of *balghami* and *safravi* matter²⁴.

Faecal Incontinence:

Some patients with large prolapsed haemorrhoids may complain of minor faecal incontinence. The large chronically prolapsed haemorrhoids may cause incomplete closure of the anal canal and predispose to the leakage of mucus and faeces¹.

In *Bawaseere reehi* there are bowel sounds due to *riyah* which can be heard over the umbilicus and this *riyah* may descends towards penis, scrotum or coccygeal region, or it may ascends towards chest, ribs, neck or shoulders. This *riyah* may leads to body and joints pain, loose motions or it may cause constipation, indigestion and loss of appetite²⁵.

Differential Diagnosis:

Rectal mucosal prolapse is frequently confused with prolapsing haemorrhoids. Patients with this condition presents with prolapse of rectal mucosa below dentate line. Bleeding may occur from trauma to this displaced vascular mucosa. Precipitating factors are same as of haemorrhoids, especially chronic straining at defecation.

Hypertrophied anal papillae are usually due to underlying anal fissure, occasionally papillae may enlarge to huge proportion to form fibrous anal polyp (but are not true colorectal polyps). Rectal polyps, melanoma, carcinoma, rectal prolapse, fissure, intersphincteric abscess and perianal endometroma should be excluded while diagnosis is made^{5,6}.

Diagnosis of Haemorrhoids

Diagnosis is made by anorectal examination. Assessment should include inspection, digital examination of the rectum in the left lateral position (Sim's position), and ideally should also include proctoscopy.

Position: Left lateral position (Sim's position) is the most popular position for anorectal examination with patient lying on left side buttocks projecting over the edge of the table with hips and knees are well flexed.

Inspection: Anal tags and 4th degree haemorrhoids are usually visible. Second and 3rd degree haemorrhoids become visible on making the patient strain as on passing stools. Thrombosed haemorrhoids and ulcerated oedematous strangulated haemorrhoids can be readily diagnosed by inspection of the rectum.

Digital examination: This should be done gently explaining to the patient what is being done, with wearing gloves and applying local anaesthetic jelly on the right index finger. Uncomplicated piles are not usually felt unless thrombosed or fibrosed.

Proctoscopy: It is essential in evaluating painless haemorrhoids. The proctoscope is well lubricated and gently inserted in the rectum. It is first introduced in the direction of umbilicus till anal canal is passed and later directed posterior to enter the rectum. Then the obturator is withdrawn and interior examined with light. The haemorrhoids will protrude into the proctoscope as the instrument is being withdrawn^{1,2,5,6}.

External haemorrhoids present as a tender, swollen, bluish or reddish, ovoid mass visible at the anal margin. Internal haemorrhoids are not usually palpable. However, if an internal haemorrhoid prolapses through the anal canal, it would appear as a reddish, moist, protruding mass. Sometimes internal haemorrhoids cause bright red haemorrhaging, especially during defecation^{1,5,6,27}.

According to Unani literature, most of the unani physicians made the diagnosis of *Bawaseer* on the basis of sign and symptoms. But some unani physicians also described general signs and symptoms that are mostly related to the patients of *Bawaseer* e.g. whitening of lower lip, scales on lips, dark (blackish tongue), *khafqaan*, hard and low volume of stool, loss of appetite, loss of libido, lethargy, greying and falling of hairs, weakening and early falling of teeth, puffiness on the eyes and face, headache, vertigo, *Ikhtilaaje meida*, *qalb* and *jigar* (stomach, heart and liver)^{4,25}.

Complication of haemorrhoids

Haemorrhage:

Profuse haemorrhage is not rare, most often it occurs in early stages of second degree haemorrhoids, bleeding mainly occurs externally but it may continue internally. Occasionally it can lead to severe anaemia.

Strangulation:

One or more of the internal haemorrhoids prolapse and become gripped by the external sphincter. Further congestion follows because the venous return is impended. Second degree haemorrhoids are more often complicated in this manner. Unless the internal haemorrhoids can be reduced within 1 or 2 hours strangulation is followed by thrombosis.

Thrombosis:

The affected haemorrhoids become dark purple and black and feel solid. Once thrombosis has occurred the pain of strangulation largely passes off but tenderness persists.

Ulceration:

Superficial ulceration of exposed mucus membrane often accompanies strangulation with thrombosis.

Gangrene:

Gangrene occurs when strangulation is sufficiently tight to constrict arterial supply to haemorrhoids. The resulting sloughing is usually superficial and localized.

Fibrosis:

After thrombosis internal haemorrhoids sometimes become converted into fibrous tissue, which is earlier sessile but repeated traction during defecation causes it to pedunculate to constitute a fibrous polyp. Fibrosis commonly occurs in subcutaneous part of primary haemorrhoids.

Suppuration:

Suppuration is uncommon, occurs due to infection of thrombosed haemorrhoid. Throbbing pain followed by perianal swelling and results in perianal or submucous abscess.

Pylephlebitis (Portal Pyemia):

Portal Pyemia is surprisingly infrequent; theoretically infected haemorrhoids should be potent cause of portal pyemia. It can occur when strangulated haemorrhoids are taken for surgery and have even been reported following banding.^[1,2]

Treatment of haemorrhoids:

The natural evolution of haemorrhoids is benign but haemorrhoids tend to get worse over time, and it should be treated as soon as it occurs. The best treatment is always prevention. Despite thousands of years and millions of patients with pain, discomfort and perceived embarrassment of haemorrhoids, exact natural cause of haemorrhoids is yet not clear so slandered treatment are, at best, imperfect, but several surgical and non-surgical techniques are used to treat haemorrhoids.

Treatment is divided by the cause of symptom into internal and external treatments. Internal haemorrhoids do not have cutaneous innervations and thus can be destroyed without anaesthetic.

Conservative Treatment

Conservative therapy is used primarily for first degree haemorrhoids but is also used in conjunction with other treatment modalities for all degrees of haemorrhoids. This is the primary form of treatment for the high risk patient as well. Conservative, nonoperative therapy centres on diet and behaviour modifications. In addition, topical medications and suppositories may be used. In summary, there are three mainstays of conservative management:

1. Bulking agents
2. Sitz baths/warm compresses
3. Local applications

Stool Bulking Agents/ Diet Modification

The idea behind diet modification and stool bulking agents is to have a soft, formed stool which eliminates straining at defecation and thereby prevents prolapse of the anal cushions. A diet which includes 20–30 g/day of fiber is recommended. This may be in the form of fruits and vegetables, raw, unprocessed wheat, oat bran or psyllium seed. There are numerous over-the counter fiber supplements available for those patients who cannot obtain enough fiber in their diets. These are in the form of tablets, powders, or wafers. It is also important to educate patients that fiber supplements are effective over a period of time and do not work instantaneously. Patients should be advised to avoid constipating foods such as cheese/dairy products, chocolate, and caffeine. The pruritus associated with haemorrhoids is also best treated with diet modification. Patients should be educated to avoid those foods that create an alkaline pH of the stool, thereby irritating the perianal area. These foods include: coffee, tea, cheese, chocolate, cola, citrus fruits and juices, beer, tomatoes, onions and nuts. Patients should also be advised to do some exercise as one of the major risk factors that predisposes to the development of haemorrhoids is lack of exercise.

Exercise that improves muscle tone is very helpful in preventing haemorrhoids. There are many exercises that help to improve muscle tone as: Swimming, running, walking, and aerobics; these activities are the best muscle toners. All of these kinds of exercises work on the abdominal area. Sphincter exercise is another wise way to prevent the development of

haemorrhoids. Kegel exercise is found to be effective in strengthening the sphincters and muscles of pelvic floor. That includes standing erect; gradually rise on the toes, at the same time, raising the hands slowly from the side, arms extended, until they are high above the head, then bend forward as if trying to touch the floor with the finger's tips. Staying active reduces pressure on veins. Pressure on veins is usually accumulated during long periods of standing or sitting. Exercise helps you lose weight and indirectly aims at one of the major reasons for getting haemorrhoids is overweight.

Sitz Baths

Sitz baths (soaking in a warm tub) are used to help soothe the uncomfortable perianal area and help reduce anal canal pressures. In some cases, baths also help in the manual reduction of prolapsed internal haemorrhoids by decreasing the swelling of the haemorrhoids and decreasing anal canal pressures. However, care must be taken to avoid prolonged soaking as this has the reverse effect and may cause perianal oedema. For those patients who do not have access to a sitz bath or cannot get in and out of a bathtub, warm compresses may accomplish the same results.

Topical Agents

There are a multitude of suppositories, foams, and topical gels and ointments marketed for the treatment of haemorrhoids. None have been proven to cure haemorrhoids, but they may temporarily provide symptomatic relief. Topical hydrocortisone may reduce symptoms caused by pruritus; however, prolonged use may cause perianal skin attenuation and injury. The ointments with an anaesthetic are beneficial only for pain relief.

Medical/Drug Treatment

Effective medical/drug therapy is useful to control the acute phase (bleeding) so that definitive therapy like banding, injection sclerotherapy, IRC, cryotherapy and surgery can be scheduled at a convenient time. Several modern and traditional drugs (oral/local) are being increasingly used in all grades of symptomatic haemorrhoids. Drugs like psyllium husk, corticosteroid creams Nitroglycerin ointment, calcium dobesilate, nifedipine etc are commonly used.

Non-operative Treatment

Numbers of methods that do not involve surgical excision are available to treat patients with haemorrhoids. These procedures are usually performed in the office setting and do not require anaesthesia.

Sclerotherapy

Morgan in Dublin first described it in 1869, and it is reserved for first and second-degree haemorrhoids. A submucosal injection of 5 ml of 5 % phenol in oil, 5 % quinine and urea, or hyper tonic (23.4 %) salt solution at the base of the hemorrhoidal complex causes thrombosis of vessels, sclerosis of connective tissue, and shrinkage and fixation of overlying mucosa. It takes only minutes to perform though an anoscope. Sclerotherapy is minimally invasive it cause some complications, like pain, Impotence, urinary retention & abscess, anaphylactic shock.

Cryotherapy

Cryotherapy used for internal haemorrhoids, and in which enlarged internal haemorrhoids destroyed, initial report related efficacy of techniques were enthusiastic. It is a time consuming techniques as compare the techniques and subsequent reports have shown disappointing results. Complications with cryotherapy are prolonged pain, foul-smelling discharge, and greater need for addition therapy. Nowadays cryotherapy is rarely used for treatment of haemorrhoids patients.

Rubber Band Ligation (RBL)

Rubber Band Ligation is most commonly used for first-second or third degree haemorrhoids.

Some authorities also recommended RBL for fourth degree haemorrhoids after operative reduction of the incarcerated prolapse. RBL relies on tight encirclement of redundant mucosa connective tissue and blood vessels in the hemorrhoidal complex. Internal haemorrhoids ligation can be performed in the office setting with one of several commercially available advance instruments so procedure becomes a one-person effort. Endoscopic variceal ligators have also been shown to be effective tools for haemorrhoid ligation. In one session RBL can be performed up to 3 haemorrhoids.

The most common complication of RBL is pain. Other complications with RBL are abscess, urinary retention, band slippage, prolapse and thrombosis of adjacent haemorrhoids.

Bipolar Diathermy

Bipolar diathermy is applied one-second pulse of 20 W until the underlying tissue coagulates. Several complications like pain, bleeding, fissure or spasm of the internal sphincter are observed. For second and third degree haemorrhoids multiple application of bipolar diathermy to the same site are required. Prolapsing tissue does not eliminate by bipolar diathermy and up to 20 % patients will require excisional hemorrhoidectomy.

Direct-Current electrotherapy

Direct current electro coagulation was utilized in 1876, and explained by Wilbur E. Keesey, MD in 1934, but doctors today oddly considered it as one of the new generation of modalities. Direct-current electrotherapy required the prolonged up to 14 minutes application of 110-V direct current to the base of hemorrhoidal complex well above the transition zone. A direct-current electrotherapy technique has not been widely accepted because of the lengthy treatment time and the limited control of prolapse in higher-grade haemorrhoids. Complications like pain, ulcer formation, and bleeding are observed in many patients.

Infrared photocoagulation (IRC)

IRC was introduced in late 1970s by Nath. In IRC coagulation of the tissue is done by focuses of infrared radiation from a tungsten-halogen lamp via a polymer probe tip. During the IRC treatment mechanical presser and radiation energy are applied simultaneously in a manner that can eliminate the disadvantage occur in electro coagulation like grounding the patients & charring of the tissue. At one time 2-6 haemorrhoids can be treated by IRC treatments.

As such IRC is free from any hazards and has proved to be an effective and safe method for treatment of early grade bleeding internal haemorrhoids, while in electro coagulation an obvious risk of electric current passing through the body, which may cause painful muscular spasms.

Surgical or operative Treatment

In normal cases hemorrhoidal diseases can be treated by the dietary modifications tropical medications. But in certain cases surgical procedure are necessary to provide satisfactory long-term relief in cases involving a greater degree prolapses. Hemorrhoidal surgery is known as hemorrhoidectomy; in hemorrhoidectomy techniques include excising internal & external components in 1-3 quadrants around the anal canal, banding of internal haemorrhoids and excising the external component or performing a circular excision of the internal haemorrhoids and Prolapsing rectal mucosa proximal to the dentate line. Recurrence following a properly performed hemorrhoidectomy is uncommon. Surgical hemorrhoidectomy can be performed with either open or closed techniques. Open hemorrhoidectomy known as Milligan-Morgan hemorrhoidectomy in which the internal & external components of each haemorrhoid are excised and the skin is left open in a 3-leaf clover pattern that heals secondarily for 4-8 weeks. Techniques developed in 1937 at UK and widely performed there. Closed hemorrhoidectomy developed in US in 1952, and it is known as Ferguson hemorrhoidectomy, in which each hemorrhoid component is excised and the wounds are closed primarily. The complication with varied frequency occurred in hemorrhoidectomy such as urinary retention, Bleeding, anal

stenosis, infection, and in continence. Alternative approach to conventional hemorrhoidectomy is stapled hemorrhoidectomy (SH), was introduced in 1993 and first described by Longo in 1998, by modifying the circular stapling device commonly used for low rectal anastomoses. It also has several complications like severe pain and bleeding, rectal perforation, retroperitoneal sepsis, pelvic sepsis.

Flavonoids and Tocotrienols for haemorrhoids treatment

Flavonoids particularly diosmin, oligomeric proantho cyaniding complexes (OPCs) and hesperidin, have demonstrated efficacy in the treatment of haemorrhoids and varicose veins. These flavonoids exhibit phlebotonic activity, vasculoprotective effects and antagonism of the biochemical mediators of inflammation.

Human trials have shown the ability of flavonoids to improve venous tone and vein elasticity assessed by plethysmography, and significant improvement in CVI, venous leg ulcers, and haemorrhoids.

Tocotrienols are collectively known as vitamin E and are identical in structure to tocopherols except for the degree of saturation in their side chain, having properties of antioxidant. Tocotrienols are found in high concentration in palm oil and rice bran oil and are well investigated for their nutrient ional, antioxidant activity, cholesterol lowering, anti-cancer effects and protection against atherosclerosis.^{1,2,3,5,6,14,15,17,23,32}

Management of Haemorrhoids According to USM

The classical literature of USM has the panoramic and compendious description of the management for haemorrhoids. According to USM, first and foremost thing is the *Izala e sabab* (cause elimination) i.e. whatever the cause it should be promptly eliminated. Since the main cause for the development of haemorrhoids is *saudavi* or *ghaleez khoon* (morbid matter), so *Tanqiya* (expelling) of this morbid matter from the body with the help of different procedure is done and its formation in the body should also be avoided.

For the *Tanqiya* (expelling) of morbid matter from the body the procedures like *Fasd* (venesection), *Hijama* (cupping), *Ta'leeq* (Leeching) or *Is'haal* (Purgation) are applied according to the condition. *Fasd* of *Rag e basaleeq* (basilic vein) is done to let down the *saudavi/ghaleez khoon* until it gets reddish and thin in consistency. If the haemorrhoids are more annoying and there are the indications of hypermia then the *Fasd* of *Rag e saphan* (saphenous vein) along with *Rag e Basaleeq* is found to be beneficial.

Hijama (Cupping) is also found to be beneficial. In this the cups are applied between the hips to expel out the morbid matter. *Ta'leeq* (Leeching) is more beneficial procedure for expelling out the morbid matter as in this procedure leeches are directly applied over the haemorrhoidal swelling or adjacent to them due to which the morbid matter lodged in the haemorrhoidal plexus directly expel out from the affected area. This also reduces the stress of affected area and diminishes the pain. But in this procedure patient's compliance is necessary.

Is'haal (Purgation) is done with the help *Mus'hilaat e suada* (purgatives for black bile) to expel out the *saudavi* and *ghaleez madda*. For this decoction of Haleela Siyah and Aftemoon is found to be beneficial. But most of the eminent Unani Physicians are not in favor of giving purgatives to the patients of haemorrhoids as the excessive motion will worst the condition.

Purification of blood is also necessary, for this Unani formulations like *Haleelajat* or *Musaffiyat* are given.

Qabz (Constipation) is also thought to be a major cause for the development of haemorrhoids so it should be countered. For this *Aspghol*, *Roghan Baadam* etc. can be given.

According to some unani physicians, haemorrhoids are also develop due to the disturbance in the *Mizaj* (temperament) of liver and intestines. If it's so then rectify the ill temperament of these organs and kept the *tabiyat* of the patient palliative and pleasant. For this some unani formulations are given e.g. *Itrifal Sagheer* and *Habb e Muqil* or *Itrifal Muqil Mulayyin* and *Murabba Haleela*.

For the stoppage of bleeding Habis e Dam Advia (Blood coagulants drugs) are given e.g. Habb e Sandroos, Sharbat e Injabar, Itrifal Muqil Qabiz, Habb e Jadwar, Majoon Khabs ul Hadeed, Safoof Tewaj, Qurs e Keharba, etc. For local application, Musakkin Alam (Analgesics) e.g. Marham Roghan e Zard, Marham Safiada Kafoori etc. are applied.

Moatadil Riyazat (Moderate exercise), Hammam (steam bath) or Dalk (massage) of lower body is advised to attenuate or liquefy the causative matter. Spicy and chilly foods and the foods that produce saudavi or ghaleez dam e.g. Red meat, dry cheese, brinjal, cabbage, dry fruits, pulses like masoor etc. are avoided.

If patient not respond to the above mentioned procedures and regimes and there is the chance that prognosis would not be good then the haemorrhoids should surgically be removed. Also, if the haemorrhoidal swellings are visible but too small to be surgically removed, then the cauterization can be done with the help of cautery or drugs^{4,7,8,13,24,25,26}.

Conclusion

Bawaseer (Haemorrhoids) is a common anorectal disorder that hampers the daily activity of suffered people and ultimately imposes sever burden on society. It has such a common occurrence is very rarely talked about due the embarrassing nature of the disease. If the treatment is delayed it gets worse day by day. Exact cause is still unknown, some modifiable and non modifiable risk factors are found to be the reason for the development of the disease upto some extent. Many treatments are available in both modern and unani system, but the best treatment is prevention. Bawaseer can be reduced by changes in life style and dietary habits. Unani therapy is also beneficial in treating the haemorrhoids as it is cheap and almost free from side effects.

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